# JOHN L. ALBRIGO, M.D.

## Patient Information Sheet

(Please fill out all 6 pages completely)

Today's Date _____________

Name_______________________________________________________ Age________

Sex: M / F Height: ___________ Weight __________ Marital Status: M / S/ D/ W

Referring Physician (name, address and phone number):

_______________________________________________________________________________
_______________________________________________________________________________
______________

Primary Care Physician (name, address and phone number):

_______________________________________________________________________________
_______________________________________________________________________________
______________

Treating Physician (s) (name address and phone number:

_______________________________________________________________________________
_______________________________________________________________________________
______________

Present Medical Complaint: Right / Left or Both (Indicate body part):

_______________________________________________________________________________
_______________________________________________________________________________
______________

Date of Onset: __________ Injury Related: Yes ___ No ____ Work Related: Yes ____ No ____

Did you bring any test with you today? (X-rays, MRI, Surgical Pictures) ( ) Yes ( ) No

List Activities that make it worse:

_______________________________________________________________________________
_______________________________________________________________________________
______________

What makes the pain decrease?

________________________________________________________________________________
________________________________________________________________________________
______________

Previous treatment for today's complaint (therapy, injections, medications, tests) Please give dates if possible:

________________________________________________________________________________
________________________________________________________________________________
______________

Medications, Vitamins or Supplements & Dosages ( ) None

*If you have a list of your medications already written down we will gladly make a copy of it.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
____________________________

Allergies to Medications: ( ) None

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
_____________________

Other Allergies: Metal, Iodine, Shellfish: ( ) None

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
_____________________

Social History:

Do you smoke? ( ) Yes ( ) No If yes: __________packs per day for __________ years.

Do you drink alcohol? ( ) Yes ( ) No If yes: How much? ________________________

Occupation and brief job description:

________________________________________________________________________________
________________________________________________________________________________
______________

Where do you live: (circle one) Home Apartment Retirement Community

Who do you live with:

______________________________________________________________________________
______________________________________________________________________________
______________

Family History: Is there any family history of (circle one): ( ) None

Stroke Heart Disease Diabetes Cancer Arthritis

If yes, please explain:

______________________________________________________________________________
______________________________________________________________________________
______________

Other: (please describe):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_____________________

**REVIEW OF SYSTEMS (CIRCLE ANY SYMPTOMS YOU EXPERIENCE REGULARLY): ( ) NONE**

Weight loss
Tingling
Vertigo
Muscle Weakness
Rashes
Upset Stomach
Chills
Bloody Stools
Diarrhea
Easy Bruising
Easy Bleeding
Poor Balance
Numbness
Other pain:

Poor Vision
Blurred Vision
Weight gain
Fatigue
Joint Stiffness
Open Sores
Excessive Thirst
Frequent Urination
Painful Urination
Hair Loss
Mood Swings
Anxiety
Depression

Leg Swelling
Tremors
Hearing Loss
Ringing in Ears
Fever
Back Pain
Cough
Shortness of Breath
Chest Pain
Palpitations
Constipation

______________________________________________________________________________
______________________________________________________________________________
______________

**PAST MEDICAL HISTORY:**
**DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE ANY THAT APPLY)**
**( ) NONE**

| | | |
|---|---|---|
| Anemia | Angina | Asthma |
| Atrial Fibrillation | Bladder Infection | Bronchitis |
| Cancer | Cellulitis | Depression |
| Diabetes | Dialysis | Diverticulitis |
| Epilepsy | Fractures | Glaucoma |
| Gout | Heart Attack | HIV |
| Kidney Disease | Kidney Stones | |
| Leukemia | Hiatal Hernia/Reflux | |
| Pancreatitis | Pneumonia | Sinus Problems |
| Sleep Apnea | Stomach Ulcers | Stroke |
| TIA | Blood clots | |
| Osteoarthritis | Heart Arrhythmia | |
| Rheumatoid Arthritis | Osteoporosis | |
| Heart Valve Disease | High Blood Pressure | |
| Elevated Cholesterol | Emphysema/COPD | Liver Disease/Hepatitis |
| Thyroid Disorders | Congestive Heart Failure | Coronary Artery Disease |

Other: ______________________________________________________________________________
______________________________________________________________________________
______________

**PAST SURGICAL HISTORY:**
**Please circle all previous surgeries: ( ) None**

| | | |
|---|---|---|
| C – Section | Cataract Surgery | Hip Pinning |
| Hysterectomy | Pacemaker | |
| Hernia Repair | Tonsils | |
| Gall bladder | TURP | |
| Thyroid | Mastectomy | |
| Cosmetic Surgery | Appendectomy | |

Right Total Knee Replacement
Left Total Knee Replacement
Revision of a Total Knee Replacement (Repeat)

Right Partial (Uni) Knee Replacement
Left Partial (Uni) Knee Replacement
Right Total Hip Replacement
Left Total Hip Replacement
Revision of a Total Hip Replacement (Repeat)

Arthroscopy
Right ACL Reconstruction
Left ACL Reconstruction

Other Surgery:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_____________________

Problems with anesthesia: (   ) Yes      (   ) No   If yes, please explain:
______________________________________________________________________________
______________________________________________________________________________
______________

Problems with Foley/Bladder Catheter (   ) Yes   (   ) No   If yes, please explain:
______________________________________________________________________________
______________________________________________________________________________
______________

Elaborate on Medical History/Medications if necessary (use separate sheet if necessary):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_____________________

PLEASE CHECK THE APPROPRIATE BOXES TO ANSWER THE FOLLOWING QUESTIONS:

Regarding your current activity level:
__ I have pain at rest.
__ I am able to walk indoors only.
__ I can walk outdoors, but usually less than six blocks at a time.
__ I can walk outdoors more than six blocks without too much discomfort.

Regarding the use of walking aids:
__ I (never, sometimes, always) have trouble climbing stairs.
__ I (never,sometimes,always) have trouble putting on socks and/or shoes.
__ My knee/knees (never sometimes, always) collapse “gives out” on me.
__ My knee/knees (never, sometimes, always) catch or lock when bending them.

# MEDICAL INFORMATION RELEASE FORM

## OFFICE OF JOHN L. ALBRIGO, M.D.

I ________________________________________, hereby authorize Dr. John L.

Albrigo/Anderson Clinic Inc. (and all of the physicians in this practice) to **furnish** and/or **obtain**

from other treating physicians, health care professionals, hospitals and/or insurance carriers

information regarding my condition, treatment and account status.

_______________________________________
Signature of patient Date